Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	Carnahan's COS; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)
002. email	From Devorah R Adler To Anna Richter; RE: phone number/personal info [partial] (1 page)	06/30/2000	P6/b(6)
003a. list	Dr Richard Helman; RE: phone numbers/address [partial] (1 page)	n.d.	P6/b(6)
003b. paper	Dr. Insurance Co.; RE: phone number [partial] (1 page)	n.d.	P6/b(6)
003c. paper	Dr. Vicki Massey; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)
003d. paper	David Jimenez; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)
003e. fax	Curriculum Vitae Richard Hellmann MD; RE: address/phone number/date of birth [partial] (1 page)	07/03/2000	P6/b(6)
003f. paper	Dr Gordon Goldman; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)
003g. email	From Devorah R Adler to Anna Richter; RE: phone number/personal info [partial] (1 page)	06/30/2000	P6/b(6)
003h. paper	Dr Ted Groshong; RE: phone numbers [partial] (3 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Anna Richter
OA/Box Number: 23736

FOLDER TITLE:
Patients' Bill of Rights Columbia, Missouri July 6 2000

2011-0638-S
ms159

RESTRICTION CODES

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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[001]

Carnahan's CoS:
Chris Sifford
W: (573) 751-4971

P6/(b)(6)

Karen Nelson (Carnahan's office)
W: 573751-8502

P6/(b)(6)

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[002]

Devorah R. Adler
06/30/2000 02:09:37 PM

Record Type: Record

To: Anna Richter/OPD/EOP@EOP

cc:
Subject: pbor - 2 stories

---------- Forwarded by Devorah R. Adler/OPD/EOP on 06/30/2000 02:09 PM ----------

Barbara D. Woolley
06/30/2000 02:08:44 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP, Karin Kullman/OPD/EOP@EOP

cc:
Subject: pbor - 2 stories

1. Kim Steil P6/(b)(6) from Kansas City, MO. Kim's name was given to me by the AMA. About 2/3 weeks ago, the MO AMA used Kim in a press event. P6/(b)(6) P6/(b)(6) Articulate. YOU SHOULD ASK KIM IF SHE HAS SUGGESTIONS ON OTHER REAL STORIES.

2. Dr. Vicki Massey, Radiologist, 816-751-2930. Dr. Massey's name was given to use by the AMA. You should talk to her about her own personal experiences and ask for other names of real stories.

July 5, 2000

PATIENTS' BILL OF RIGHTS EVENT

DATE:	July 6, 2000
LOCATION:	Jesse Auditorium, University of Missouri Columbia, Missouri
EVENT TIME:	11:05 am – 12:20 pm
FROM:	Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

To highlight the differences between the Republican Senate Patient Protection bill and the Norwood-Dingell Patients' Bill of Rights, and to praise Governor Carnahan for his leadership in passing a strong state version of the Patients' Bill of Rights.

II. BACKGROUND

In three separate votes in recent weeks, the Senate has illustrated that it requires only one more vote to succeed in passing a bipartisan Patients' Bill of Rights similar to the Norwood-Dingell legislation that has already achieved broad bipartisan support in the House of Representatives. Today you will illustrate the difference between a patients' bill of rights in name only and one that will make a real difference in assuring the health of all Americans in all health plans, and underscore that the Congress is one vote away from achieving a majority vote for a bipartisan and real Patients' Bill of Rights.

THE SENATE IS ON THE VERGE OF PASSING A REAL PATIENTS' BILL OF RIGHTS. You will underscore today that the Senate is only one vote away from passing a strong, enforceable, Patients' Bill of Rights, similar to the bipartisan Norwood-Dingell Patients' Bill of Rights. Today, you will underscore your optimism that the Patients' Bill of Rights will be enacted this year and highlight your belief that the momentum for the Norwood-Dingell legislation is undeniable. That legislation, endorsed by over 200 health care provider and consumer advocacy groups, is the only bipartisan proposal currently being considered that:

- Protects all Americans in all health plans;
- Protects patients accessing emergency room care from financial sanctions;
- Guarantees access to necessary and accessible health care specialists;

- Guarantees access to a fair, unbiased and timely internal and independent external appeals process to address health plan grievances;
- Provides assurance that doctors and patients can openly discuss treatment options; and
- Includes an enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions, regardless of the plan's intent.

THE SENATE BILL IS AN EMPTY PROMISE. You will underscore your belief that the bill passed by the Senate is a Patients Bill of Rights in name only. It would:

- **Leave more than 135 million Americans without the guarantee of any basic protections.** An independent study confirms that the protections in the Senate bill, which are limited to self-insured health plans, would apply to only 2 percent of HMOs nationwide – less than 1 in 10 people in managed care.

- **Subject patients accessing emergency care to high financial penalties.** The Republican amendment allows plans to penalize patients who did not receive prior authorization before going to the emergency room by requiring higher levels of cost sharing. Patients should not pay a high financial penalty because they did not have time to stop during their emergency and call their plan.

- **Fail to guarantee access to necessary health care specialists.** Plans are not required to provide access to necessary health care specialists even if they are out of network. A plan could meet the requirements of the Senate bill by providing "access" to a specialist who was 100 miles away from the patient or one that did not have handicapped accessible facilities.

- **Fail to provide access to important clinical trials.** The Senate bill limits access to clinical trials for patients with cancer. Patients with Parkinson's, Alzehiemer's, multiple sclerosis, and other diseases would not be guaranteed access to appropriate clinical trials and potentially lifesaving treatments.

- **Establish a wholly inadequate enforcement mechanism that prevents patients from holding health plans accountable when they make harmful decisions.** The liability provisions in the Senate bill fails to ensure accountability for negligent actions by a health plan in denying or delaying needed medical treatment. Patients would have to prove that the health plan intentionally harmed them through the denial of care. In addition, the Senate bill provides that there is no liability for damages at all if a self-insured plan contains other types of benefit options.

- **Undermine current protections established by states providing patient protections.** This new, inadequate federal remedy will preempt current state laws

allowing patients to bring actions under state law that challenge health plan decisions to delay or deny a benefit.

YOU WILL NOT SIGN A PATIENTS' BILL OF RIGHTS THAT REPRESENTS AN EMPTY PROMISE. Today, you will reiterate your refusal to sign legislation that does not provide strong patient protections for all Americans in all health plans and include meaningful enforcement mechanisms. To date, there is no legislation other than the Norwood-Dingell bill that meets your fundamental criteria: that patient protections are real and that court enforced remedies be accessible and meaningful.

III. PARTICIPANTS

Greeters:
Dr. Manuel Pacheco, President, University of Missouri System
Dr. Richard Wallace, Chancellor, University of Missouri-Columbia
Brady Beaton, Provost, University of Missouri-Columbia
Kee Groshong, Vice Chancellor for Administration, University of Missouri-Columbia

Stage Participants:
30 local Doctors and Nurses

Program Participants:
YOU
Governor Mel Carnahan
Dr. Manuel Pacheco, President, University of Missouri System
Doctor TBD

Receiving Line Participants:
See attached list.

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will arrive at the University of Missouri and will be greeted by University officials.
- **YOU** will be announced onto the stage, accompanied by Governor Mel Carnahan, University of Missouri System President Manuel Pacheco, and Doctor TBD.
- President Manual Pacheco will make welcoming remarks and introduce Governor Mel Carnahan.
- Governor Mel Carnahan will make brief remarks and introduce Doctor TBD.
- Doctor TBD will make brief remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline, and depart.

- **YOU** will participate in police and driver photos.
- **YOU** will participate in a receiving line with leaders of healthcare organizations.
- **YOU** will depart the University of Missouri.

VI. REMARKS

To be provided by speechwriting.

VII. ATTACHMENT

- Receiving Line Participants

PHOTO RECEIVING LINE PARTICIPANTS
July 6, 2000

Martha Donnel, Executive Director, American Lung Association
Eileen Fagan, President, Missouri Breast Cancer Coalition
Roger Gooden, Board Member, Missouri Association of People with AIDS
John Howell, President, Missouri Psychological Association
Kathy Meath, Board Member, The ARC of St. Louis
H. Gerry Murrell, Past President, Missouri Medical Association
Richard Oliver, Director, School of Health Related Professions, University of Missouri-Columbia
John O'Shaughnessy, Executive Director, Health Sciences Center, University of Missouri-Columbia
Rosemary Porter, Dean, School of Nursing, University of Missouri-Columbia
Desma Reno, President, Missouri Nurses Association
Cathy Sullivan, Board Member, American College of Physicians
Margaret Sullivan, Board Member, American College of Physicians
Brenda Tibbles, Board Member, Missouri Cancer Society
Weldon Webb, Associate Vice Chancellor, Health Services Center, University of Missouri-Columbia
Keith Weinhold, Interim Director, University Hospital, University of Missouri-Columbia
Daniel Winship, Vice Chancellor, Health Sciences Center, University of Missouri-Columbia

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003a. list	Dr Richard Helman; RE: phone numbers/address [partial] (1 page)	n.d.	P6/b(6)

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[003a]

Dr. Richard Helman – President of the Medical Society of Greater Kansas City
Also a practicing physician – diabetes specialist
Phone Numbers: O: (816) 421-3700 (after 5 pm – 816-480-2710)
P6/(b)(6) (don't leave msg – old v-mail & can't get msg)
P6/(b)(6)

Dr. Ted Groshong – Medical Director of the Children's Hospital, University of Missouri
W: (573) 882-6882
P6/(b)(6)

Dr. Daley – General Internal Physician, Boone Hospital Center
W: (573) 815-2236

Georgina Gonzalez – Nurse (per Dr. Daley's recommendation)
W: (573) 815-2236

Dr. Mark Adams – Out until Wed
W: (573) 443-2402

Sue Kendig – Nurse (per MNA)
P6/(b)(6)

Dr. Gordon Goldman
W: (573) 878-7333
P6/(b)(6)

Dr. Jerry Kennett
W: (573) 256-3065

Doug Bouldin – RN
(636) 528-8585
P6/(b)(6)
P6/(b)(6)

Real
People
Notes

Olathe, Kansas → Kansas City, Kansas

300 letters to Sen Ashcroft

PBOR →

created a letter urging

[go on weekdays until Sat - 1/month]

Dr. Reardon

July 99 Primary CNS lymphoma

Brain tumor

Surgery yrs early had tumor removed + radiation

New tumor in 99 totally inoperable place - no longer

went through referrals

pursued treatment

Phase 3 clinical

done since 1981 but still deemed "experimental"

July - Oct → tried to obtain

Humana continually denied -

In Oct don't take action - lose

Dr's proceeded w/o approval -

went through states - Internal Review Board

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[003b]

Local News Station → 41 stats

Dr. Insurance Co Refered to & won't

Attorney on case since Oct/Nov 99]
going 8 months into

settlement conferences

expert witnesses

Clinical Coordinator @ Trinity Lutheran Hospital → public hospital

Ron Hayler → WORK: (816) 751-2848

P6/(b)(6)

- Kansas City Star -

Another gentleman weren't told about treatment

Head-city of Headquarters -

"41" → "Humana"

"Umana"

[redacted] Geographical -

"experimental + investigational"

Medicine –
experimental + investigation

1981 customarily / other insurance
Companies

Ron Hoyter – RN
Clini
Blood Brain Barrier Disruption
(BBBD) ↗
treatment

★ ⟶ Husband is 38 years old + 2 Kids
9 + 2 yrs old 35

★ Been on disability since 1995
used to be a
Xerox Repairman

Dr. New or Newolt
Newwelt from Oregon – 1st — pioneered BBBD is now

Trinity Facility ⟹

Litigation: has gone back from
state to fed to state Now in Federal –

MD And. 792 2121
(713) ~~792 2161~~

Dr. Charles Conrad → referred now at MD Anderson Hospital →

MD Anderson Neuroanscologist - research

new 50%

Primary Doctor → [Humana] →

Oncologist → →

Dr. MARK DeWolfe —

didn't feel was seeing neuro issues -

[redacted]

Public Relations

Health University of Mo. TED GROSHONG

Med director of the Children Hospital – Chairman of Pediatric department

~~Arisa Laws~~

~~House Bill~~

[committee Campaign Chairman for Tim Harlan] →

Plans are now accountable **b/c of Mo Bill** → **why need fed legs**

Problem now is Arisa Plans b/c are federal –

if patients are denied **treatment/coverage no right to sue · HC Co isn't accountable; PLUS → Arisa's review board criteria too lose - no requirement to be PhD/MD**

Medicaid Patients - specialists - access to specialists difficult – contract w/ people in St. Louis – could be further away –

2 cases of Kids w/ Chronic [redacted] kidney → for one patient would've been delayed a wother

Her insurance Company contracted w/ St. Louis Hospital → **For the transplant**

W/both – **ended up okay** –

I took 3 months of Fighting w/ insurance company

Managed Care Plans w/

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Phones: P6/(b)(6)

P6/(b)(6)

DR VICKI MASSEY - Radiologist

9am Her time →

[003c]

In support of federal, "meaningful" bill -

"Pseudo" bill v. Norwood - Dingell

in Kansas City, Mo

Radiation Oncologist - grad in 85 - finished

Practiced in Kansas City

Personal experience →

a patient indirectly that has been denied services -

Hospital + physicians are ~~cover~~ treating + payment will be negotiated later

treatment is "experimental" but same procedure if covered by another

"medical necessity" →

2 Hours → DR MASSEY

a lot of plans are employer plans that fall under the

Arisa Act - a federal bill

Real issue is Physicians → don't want more suits

Someone needs to take responsibility

decision

Medical

if Dr. makes reccommendation should be liable ŝ if HMO override

HMO's for first time could be

Doctors are assuming liability -

~~if Dr~~ Patients to be taken care of -

don't have a long time to fight it →

Pediatrics →

Patients should Participate in the decision for treatment ;

Physicians -

Everyone was new -

Lung cancer
w/in year disease spread to brain

b/c insurance changed; had to switch Dr.'s

insurance Co wouldn't

* issue of disagreeing of care - right to appeal decision another → "not covered" - not that "not necessary"

diabetes - ~~not med~~ strips - not covered under policy - necessary to maintain
I get out of it as a "coverage issue"

don't know how many people appeal - *

don't know

until - feel so isolated ; overwhelmed - if recommendation is taken away

Not looking

quick external evaluation - have protection - dispute resolved quickly

- Not luxury of six month review -

Family Doctor DR. Kivlahan
- cabinet under Carnahan -

Currently:

Community Health Center → Family Health Center
50% of time is a director + Founder
Associate Chief of Staff 9 Hospitals in Health Science Center @ University
Clinical outcomes for medical errors -
trying to improve clinical quality

2 observations:

Medicare HMOs from Columbia burned in Chicken Factory fire -
infection down to arm -
left Medicare HMO & went back to regular Medicare

Speciality Access Important +

man - late 50's -
High blood pressure - MRI - Tumor around spine -
surgery - - for months -
HMO dragged feet about getting Mayo Clinic
delay of treatment issue
→
- nightly + daily upper/lower body spasms -

current HMO doesn't allow access to knee — can now be months away

Access & Delay in Service issues — Denial / Delay / Access

— Hassle factor significant —

Baby 3 hospitals in 4 days

(573) 443 2402 → pager 573 876 6594

Jennifer Clark (573) 443-2402
- Columbia Orthopedic Group -

Dr
~~Coleeane~~ Coleeane ~~Kivlahan~~
Kivlahan

~~former dept~~
director of dept of Health for Mo

large Medicaid(?) → Medical director of

PG 5734443 8347
0182

(573)

Justin Coleman →
e-mail to
Justin -

Pager (573) 443 8347
pager#: 0182
Code/Pin →

kivlahanc@health.missouri.edu

Doctor Daley → General Internal Medicine - mostly w/ older people

Practicing for almost 30 years - Columbia Missouri - [Community Hospital = Boone Hospital center

Good affordable accessable care.

Demeans Patient Patient Protection Act ; PBOR

battling illness is tough enough ;

Public county Hospital in central leased + run by

Has not had any full blown suits →

Nurse → Georgina Gonzalez → (573) 449 8350

walks difficulties of dealing →

Dr. Goldman
THURSDAY – President of Missouri State Medical Association

Chairman of Legislative Affairs

Dr. Jerry Kennett →

Cardiologist → in Columbia

Missouri State Medical association
(573) 636-5151

Me. Swarens →

Michael Daley —

Dan Windchip —

Ted Groshong —

Jennifer Clark →

Jerry Kennett → (573) 256 3065

↳ Cardiologist →

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003d. paper	David Jimenez; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Anna Richter
OA/Box Number: 23736

FOLDER TITLE:
Patients' Bill of Rights Columbia, Missouri July 6 2000

2011-0638-S
ms159

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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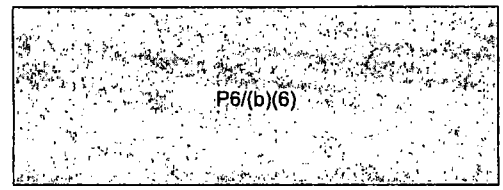
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

DAVID JIMENEZ:

Neurosurgeon -

Columbia @ the University of Mo

office: (573) 882-4908



Pediatric Surgeon -

[003d]

[Craneo-Synostosis →

surgury to correct - taking entire skull apart -

Blood transfusion - ICU stay about a week;

Practing Physician - since 1981 for 9 years a Professor 73-81 @ UMKC school of medicine

57 year old → ↻

President of Medical Society of Greater Kansas City → Richard Helman

RIC 1st med community ↓

got Bluecross Blueshield to back off of ——

✱ More protection for patients on medical necesity - ——

HMOs have negotiated coverage w/ employers @ muchtoo low levels →

✱ use this new rule ↓;

① Patient of Orthopedic Surgeon

referred person of —

replace the tissue — cheaper to amputate it —

life Costs 3/4X as much to save leg - not deemed medically necessary

Kansas City Star →

② Refugee from Sudan -

Christian + African; Very poor; Type 1

diabetes - 4 injections of insulin/day -

needs to check blood sugar I send $ to parents

it wasn't medically necessary → "not covered" OR "not medically necessary"

③ Lady w/ ~~Amputated~~ Leg → HMO wouldn't cover a specialist

Lost a leg ; 4 or 5 years ago –

said she was fine →

Was his patient ; HMO wouldn't cover a patient →

writes a column for the medical society

Racial injustice for managed care →

Patient safety + electronic medical records →

~~Medicare Fraud~~

HER EMPLOYER ONLY OFFERED AN HMO:

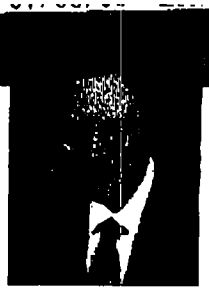
1997 →

Thinks State bill good idea → one of better bills around. But hard to implement

Most patients don't even know their rights yet –

federal law would be great help →

on
nonabelian groups



by **Richard Hellman**
President, Metropolitan Medical Society

Medical Necessity: The Struggle for Patients' Rights

On the surface, the term medical necessity seems harmless enough. Many of us think of it as a simple term which defines a medical service so important for the patient's well being that a reputable insurer would not question the necessity of providing this service to the patient. At times this definition has worked well, but in recent years, the term has been wielded like a shield to protect the insurer from legitimate claims for medical care.

Our patients complain that fighting insurance companies over denied services is much like running a gauntlet - a test of will, of wits, and of endurance. Only the few, the proud, and the brave prevail. But many of our patients hardly fit that mold. They are good people, but not warriors. And they usually do not prevail.

One of the outstanding orthopedists in our community told me of his experience. He was referred a patient who had a soft tissue sarcoma of the thigh. He examined the patient, reviewed the data, and told the patient the good news. He would be able to successfully perform a limb salvage operation and both cure the cancer and save his leg. The patient wanted the operation, but the surgery would first need to be approved by his HMO. The surgeon, who is widely respected nationally for his work on limb salvage procedures in bone and soft tissue tumors, called the HMO, but was told by them that the procedure would not be approved because it was not medically necessary. The medical director of the insurance company explained it this way: it would be medically necessary for the surgeon to amputate the leg to cure the malignancy, but the much more expensive limb salvage operation, although more aesthetically pleasing, was not necessary.

To his credit, the outraged surgeon told the reviewing physician that he would send a letter to the *Kansas City Star* detailing the plan's decision to deny the limb salvage surgery. Upon hearing that their decision was about to become public, the insurance company quickly decided that it was medically necessary, after all, to allow the limb salvage operation. The surgery was successful and the patient survived.

Although our attention is drawn first to high profile or dramatic cases such as this one, probably the more important issues are the commonplace denials, which occur so frequently. We almost forget that these are what the patients are most likely to encounter. Another example, a patient of mine, a thirty-one year-old man with insulin-requiring diabetes, came into my office several weeks ago. He is a permanent resident of the USA and hopes to become a citizen soon. He works full time in our area, doing physical labor. He sends much of his meager income to his parents, who live in Sudan, and are starving. Although he gives himself four injections of insulin daily, he had not been checking his glucose levels at home or at work. His insurance company told him that the glucose strips used for checking his glucose levels at home were not a covered benefit, despite the fact that they are clearly essential to his care and, by all reasonable medical standards, were medically necessary. He had a choice to buy strips or send money for his parents to eat. He chose the latter.

Could he have appealed? Yes, and he would have won if an external agency had reviewed the case. He was intimidated by those who told him it would not be covered, and he did not understand the system at all. For every high profile case, there are countless others who quietly accept the decision not to provide the needed service and do not get the care they need when they need it.

In several states, including Missouri, there now is law that will allow citizens to appeal decisions made by insurers that cover both medical necessity and coverage decisions. This is particularly important, since insurance companies have found that the more narrowly they define medical necessity, the easier it is to avoid external review of their decisions. Medicare, in its managed care products (Medicare HMOs), have had such a process in place for several years, using an external review agency called the Center for Health Dispute Resolution (CHDR).

These reviews have helped to level the playing field. They provide an easier process for both the patient and the doctor to navigate. Unfortunately, outside of these Medicare contracts, few insurance contracts written today provide the protections for patients that would help them deal with coverage denials. In contrast, the current reality is that many cost-conscious companies often make decisions on coverage and medical necessity that put both the patients health and well-being at risk.

When we look at contracts written by insurers, I hope we will consider medical necessity issues to be just as important to us as the fee schedules. When there is not a fair process for appeals of all types, not only does the patient suffer, but we are all diminished by the fact that we could have done more to protect the patient. In the next few years, we will have a great opportunity to take back our profession, but only if the public believes that we are their strongest advocate.

president's page

by Richard Hellman
President, Metropolitan Medical Society,
rhellman.hellman@hensmann.com

Racial Injustice and Patient Care

Imagine for a moment what it would mean to you if one of your family members was stricken with incurable cancer, and despite their agonizing pain, no neighborhood pharmacy would fill a prescription for morphine. Impossible, you say, simply impossible. Yet, in a recent article in the *New England Journal of Medicine*, the authors presented evidence that this is a commonplace occurrence in the non-white neighbor hoods of New York City.

Is this an isolated case, an aberration that is more due to the fear of theft than the insensitivity to patient need? Perhaps so, but there is no good evidence to suggest that this is an isolated problem. In fact, another recent *New England Journal* article provided compelling and deeply disturbing evidence that African-American patients on chronic dialysis were less likely than Caucasian patients to be referred for evaluation for renal transplantation. Why should this be happening? Certainly it is common knowledge today among physicians that renal transplantation offers by far the best outcomes for the vast majority of patients with chronic renal failure.

There are other examples of racial disparity in the literature. In another report, African-American patients with symptoms of coronary heart disease were less likely to receive a thorough work up for coronary artery disease. In another study, the chance that an African-American patient with insulin requiring diabetes would receive intensive insulin therapy was practically zero, despite the fact that this form of therapy is now being more regularly used in both Type 1 and Type 2 diabetes.

But what about our medical community? Is racial injustice a problem for us as well? I know that our published data, accumulated between 1981 and 1996 and published in *Diabetes Care* in 1997, showed that all patients with diabetes, regardless of race or gender, who received intensive therapy benefitted greatly, lived longer, and were less likely to suffer renal failure. African-American patients and Hispanic patients responded particularly well to this form of therapy, but in this reported study, those in our community were very unlikely to be receiving this form of therapy outside of our practice. But this data is now more than four years old, and I hope no longer represents the state of diabetes care in the African-American community in our community today.

Where tempers really flare is when we try to discuss why there is racial injustice in medicine. It is here where most of us flounder badly, since, for better or for worse, none of us can see the world through another's eyes. All of us have anecdotes that profoundly affect our opinion, but like the blind men and the elephant, our perception of the truth is often very limited.

My perception is that most of the racial injustice we are talking about is inadvertent and best handled by education. Eight years ago, I began a Diabetes Symposium, entitled the "Challenge of Diabetes" and to head the first symposium, I brought in a brilliant and distinguished physician-scientist, a friend of mine for many years, who also happens to be African-American. During the question and answer period, one of the community physicians, asked a question that displayed an appalling insensitivity to race relations and a very low and unrealistic set of expectations of the self-care behaviors of his African-American patients.. There was an audible gasp from the audience. While I was trying to decide whether it would be obvious if I ducked under the table at that moment, my friend, who was a skilled negotiator as well as a gifted speaker, went ahead and handled the situation well. He educated the physician in a very gentle but clear way, and with considerable tact, without humiliating him in this public forum. Ultimately, the physician was grateful and so was I.

The problem , however, is that low expectations of patients or of others is a form of prejudice that can be very destructive, however inadvertent. If you think that a patient will not be able to complete a course of therapy because of your prejudice, and you are wrong, the patient suffers. This is not merely a question of race. In the area of cardiology, there is abundant evidence that physicians' evaluation of chest pain in women was frequently hampered by their prejudice that chest pain in women was a much less serious problem than in men. In the past two years, the medical literature has finally made it clear that physicians prejudice about the cause of the chest pain in women had inadvertently put the women at risk for poorer outcomes. As in the issue with racial injustice, I believe that in many cases, the prejudices will be amenable to education, and much less so to name-calling.

In the coming months, I hope that the Medical Society will be a forum for constructive dialogue on these important issues. This essay is hardly the definitive statement on this topic, but I hope it is a beginning of a process that will help improve our care of all the members of our community. Please write to me or to us and provide your insights and comments. They will be most welcome.

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Anna Richter
OA/Box Number: 23736

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CURRICULUM VITAE

[003e]

RICHARD HELLMAN, M.D.
F.A.C.P., F.A.C.E.

PRIVATE PRACTICE:

April 16, 1993 to Present: Private Practice of Diabetes Mellitus and Endocrinology. Main Office is located at 2750 Clay Edwards Drive, Suite 210, North Kansas City, Missouri, 64116. The satellite office is located at 5701 W. 119th Street, Suite 320, Overland Park, Kansas, 66209.

July 1, 1994 to January 1, 1997: Medical Director of The Diabetes Program located in Trinity Lutheran Hospital, Kansas City, Missouri, 64108.

October 1, 1986 to April 15, 1993: Private Practice of Diabetes Mellitus and Endocrinology at 2940 Baltimore, Suite 400, Kansas City, Missouri, 64108.

October 1, 1986 to July 1, 1994: Medical Director of The Diabetes Treatment Center, located in Trinity Lutheran Hospital, Kansas City, Missouri, 64108.

October 1, 1981 to September 30, 1986: Medical Director, Midwest Diabetes Care Center, 6700 Troost, Kansas City, Missouri 64131. Private Practice of Diabetes Mellitus and Endocrinology at the same location.

PERSONAL DATA:

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Born: P6/(b)(6)

Email: rhellman.hellman@hensmann.com
richardhellman@sprintmail.com

PROFESSIONAL QUALIFICATIONS:

Fellowship: (Endocrinology and Metabolism)
University of Kansas Medical Center
Kansas City, Kansas
January 1972 - December 1972
(NIH Funded Traineeship)

Residency: (Internal Medicine)
University of Kansas Medical Center
Kansas City, Kansas
July 1967 - June 1968 and
January 1971 - January 1972

Internship: (Straight Medicine)
University of Kansas Medical Center
Kansas City, Kansas
July 1966 - June 1967

Medical School:
Chicago Medical School
Chicago, Illinois
September 1962 - June 1966
Degree Awarded: M.D.

POSTGRADUATE EDUCATION:

"The Physician's Management Education Program"
University of Missouri-Kansas City
Henry W. Bloch School of Business & Public Administration
September 26, 1997 - December 6, 1997 (certificate awarded)

STATE MEDICAL LICENSE(s):

Missouri	MD R4520	January 1, 1972 to Present
Kansas	04-14786	Active: May 1994 to Present Inactive: November 1983 to May 1994 Active: June 1971 to October 1983

CERTIFIED BY NATIONAL BOARD OF MEDICAL EXAMINERS: 1967

SPECIALTY CERTIFICATIONS:

Certified in Endocrinology and Metabolism by the American Board of Internal Medicine, October 1973.

Certified in Internal Medicine by the American Board of Internal Medicine, June 1972.

HONORS:

Elected to Membership in the American Thyroid Association, October, 1997

Elected to Fellowship in the American College of Endocrinology, April 1995.

Elected to Fellowship in the American College of Physicians, April 1977.

FACULTY APPOINTMENTS:

November 1, 1998- Present:	Clinical Professor of Medicine, University of Missouri/Kansas City School of Medicine.
October 1, 1981 - April 30, 1995:	Clinical Associate Professor of Medicine, University of Missouri /Kansas City School of Medicine.
September 1, 1975 - September 30, 1981:	Associate Professor of Medicine and Docent, University of Missouri /Kansas City School of Medicine.
July 1, 1973 - August 31, 1975:	Assistant Professor of Medicine and Docent, University of Missouri /Kansas City School of Medicine.
January 8, 1973 - June 30, 1973:	Assistant Professor of Medicine, University of Missouri, University of Missouri /Kansas City School of Medicine.

COLLEGE:

New York University (University College of Arts and Sciences) 1958 - 1962
Degree Awarded: B.A. (Mathematics), Major in Mathematics (Member of Mathematics Honors Program)

New York State Science Scholarship, 1958 - 1962
Honor Dean's List, 1958 - 1960

MILITARY SERVICE:

United States Air Force:	August 1,1968 to November 5, 1970 Honorable Discharge

NATIONAL COMMITTEES AND BOARDS {also see FOUNDATION}:

1999	Member, Performance Measurement Coordinating Council (PMCC) Clinical Logic Work Group, a collaborative venture between American Medical Accreditation Program (AMAP), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA)
1999	Member, Board of Directors of the American Association of Clinical Endocrinologists
1999	Member, Legislative and Regulatory Committee of the American Association of Clinical Endocrinologists
1999	Member, Prenatal Care Work Group of the Performance Measures Advisory Committee (PMAC) of the American Medical Association's AMAP (American Medical Accreditation Program)
1999	Member, Risk Stratification Work Group of the Performance Measures Advisory Committee (PMAC) of the American Medical Association's AMAP (American Medical Accreditation Program)
1998- Present	Member, Task Force on Revision of America Association of Clinical Endocrinologists (AACE) Guidelines on Diabetes Mellitus
1998- Present	Member, Performance Measures Advisory Committee (PMAC) of the American Medical Association's AMAP (American Medical Accreditation Program)
1998 – Present	Member, Diabetes Work Group of the Performance Measures Advisory Committee (PMAC) of the American Medical Association's AMAP (American Medical Accreditation Program)
1998 - Present	Member, Continuing Medical Education (CME) Committee of the American Association of Clinical Endocrinologists
1996 - 1998	Member, Third Party Committee, Social Economic and Government Activities Legislative Committee of the American Association of Clinical Endocrinologists

NATIONAL COMMITTEES AND BOARDS {also see FOUNDATION}: (Continued)

1998 - Present 1995 – 1996	Member, Legislative Subcommittee, Social Economic and Government Activities Legislative Committee, of the American Association of Clinical Endocrinologists
1994	Nominee for Nominating Committee for The Endocrine Society
1992 - 1994	Appointed to Governmental Relations Committee of the American Diabetes Association
1991 - 1994	Appointed to Clinical Initiatives Committee of The Endocrine Society
1991 - 1994	Member, Clinical Initiatives Subcommittee on Clinical Practice Guidelines of the Endocrine Society
1991 - 1994	Chairman of the Diabetes Treatment Centers of America Medical Advisory Board's Committee on Physician Advocacy
1989 - 1994	Medical Advisory Board of the Diabetes Treatment Centers of America

EDITORIAL APPOINTMENTS AND BOARDS:

1999	Associate Editor, ***Endocrine Practice***, the scientific publication of the American Association of Clinical Endocrinologists.
1999	Member, Editorial Board of ***Clinical Diabetes***, the scientific publication of the American Diabetes Association.
1999	Section Editor, Endocrinology Literature Review, ***Internal Medicine World Report***
1999	Manuscript reviewer, ***Journal of Diabetes and its Complications***

STATE AND METROPOLITAN COMMITTEES:

Metropolitan Medical Society of Greater Kansas City

1999	President-Elect, Metropolitan Medical Society of Greater Kansas City
1998 - Present	Member of Informatics Committee, Metropolitan Medical Society of Greater Kansas City
1997 - 1998	Elected Secretary of the Metropolitan Medical Society

STATE AND METROPOLITAN COMMITTEES: (Continued)

Metropolitan Medical Society of Greater Kansas City (Continued)

1997 - Present	Member of the Board of Directors (officer)
1995 - Present	Chairman of the National Governmental Relations Committee
1994 - Present	Member of the President's Committee
1994 - 1995	Chairman of the Federal Health Care Reform Committee
1993 - 1994	Chairman of the Federal Health Care Reform Task Force
1993 – 1997	Member of the Physician /Patient Relations Committee
1995 – Present	Member of the State Governmental Relations Committee
1994 - 1995	Member of the State Health Care Reform Committee
1993 - 1994	Member of the State Health Care Reform Task Force

Missouri State Medical Association:

1999	Member, Missouri Institute of Quality Health Care of the Missouri Patient Care Review Foundation.
1999	Member, Diabetes Work Group, Missouri Institute of Quality Health Care of the Missouri Patient Care Review Foundation.
1998 - Present	Member, Commission on Continuing Education and Health Manpower of the Missouri State Medical Association.

American Diabetes Association:

1992 - 1994	Member of the Board of Directors, Missouri Affiliate of American Diabetes Association
1990 - 1994	Member of the Professional Education Committee of Missouri Affiliate of American Diabetes Association
1990 - 1994	Member of the Patient Education Committee of Missouri Affiliate of American Diabetes Association

STATE AND METROPOLITAN COMMITTEES: (Continued)

American Diabetes Association: (Continued)

1986 - 1994	Member of the Board of Directors, Kansas City, Missouri Chapter of American Diabetes Association
1986 - 1989	President of the Kansas City, Missouri Chapter of American Diabetes Association
1986 - 1989	Chairman of the Patient Education Committee of the Kansas City, Missouri Chapter of American Diabetes Association
1986 - 1988	Member of the Long Range Planning Committee of Missouri Affiliate American Diabetes Association
1985 - 1986	Chairman of the Liaison Committee of the Missouri Affiliate American Diabetes Association
1984 - 1986	Member of the Committee on Mergers, Missouri Affiliate of American Diabetes Association
1984 - 1986	Vice-President of the Heart of America, Affiliate of American Diabetes Association
1983 - 1984	Secretary of the Heart of America, Affiliate of American Diabetes Association
1982 - 1984	Chairman of the Long Range Planning Committee, Heart of America, Affiliate of American Diabetes Association
1982 - 1984	Chairman of the Public Education Committee, Heart of America, Affiliate of American Diabetes Association

PROFESSIONAL ORGANIZATIONS:

- American Association of Clinical Endocrinologists
- American College of Endocrinology
- American College of Physicians
- American Diabetes Association
- American Diabetes Association of Greater Kansas City
- American Medical Association
- American Thyroid Association
- Johnson County Medical Society
- The Endocrine Society
- Kansas Medical Society
- Metropolitan Medical Society of Greater Kansas City
- Missouri State Medical Society

NATIONAL FOUNDATION:

Diabetes Treatment Center of America Foundation:

1990 - 1993	Member of the Liaison Committee with Academic Faculty of Diabetes Treatment Center of America Foundation
1989 - 1993	Member of the Board of Directors
1987 - 1993	Member of the Research Committee
1987 - 1993	Member of the Quality Assurance Committee

OTHER MEDICAL FOUNDATIONS:

1990- Present	Founder and Medical Director, Heart of America Diabetes Research Foundation. My staff and I direct the research of the Foundation which is a not-for-profit Foundation and has a 501(c)(3) exemption status from the IRS.

The two missions are:

1. Initiate a series of long-term prospective studies to evaluate various treatment modalities involving intensive insulin therapy and their effect on clinical outcome.

2. To evaluate neuro /behavioral issues that affect diabetes.

CURRENT RESEARCH OF FOUNDATION:

- Hellman, R., et.al: One of fifteen Principal Investigators in the U.S. in a Phase II Trial of MiniMed Implantable Insulin Pump, a Multicenter International Trial; first implant ever in Kansas City at Trinity Lutheran Hospital. To date, 13 implantations have been performed in Kansas City, all at Trinity Lutheran Hospital, and followed by our research team. 1990 - Present.

- Hellman, R., et. al: Health Outcomes research on the effect of intensive therapy for Diabetes Mellitus on both Type I and Type II diabetes. This is a 14-year study of the outcomes of 209 patients followed for a medium duration of more than 11 years. First phase of study completed. Published in ***Diabetes Care***, March, 1997.

PAST RESEARCH:

- Hellman, R., Kilo, C., Guthrie, R., Hiar, C.E., et.al.: "An Immunologic Method for the Measurement of Hemoglobin A1C." A multicenter field trial of a new instrument designed by Miles Laboratory, 1990-1991. Study completed. Published in *Diabetes Care*, November 1992.

president's page

by **Richard Hellman**
President, Metropolitan Medical Society,
rhellman.hellman@hensmann.com

Patient Safety and the Electronic Medical Record

Few reports have had the explosive impact of the Institute of Medicine report on patient safety. For a while it seemed that nearly every politician had a solution, one more draconian than the other. With the American Medical Association on one side, and the authors of the report on the other, we were treated to a tug-of-war that is still unresolved.

Sadly, there is more than a kernel of truth to the report. Although the data were ancient and the exact numbers will never be known, most of us will concede that in many ways our health care system provides hazards to the unwary and pitfalls in the most complex care settings. This truth is even more ironic because of the popular perception of medical care. The public appears to believe that modern medicine can and should solve nearly every problem. A complete cure, a perfect surgical result, or a healthy newborn, should be not only expected, it should be demanded. Oh, if only we could deliver that with the regularity that the public expects. But we cannot. Barriers to good outcomes often defeat the best intentions.

Sometimes the barrier is basic biology. Ninety year-old patients have hearts that cannot be whipped incessantly. Neither do their immune systems have the same vigor of their youth. On the other hand, we know now that the price of saving a very premature infant may be a much higher chance of retardation or disability of the child, problems that may be still evident years after the initial heroic rescue in the neonatal ICU.

Sometimes the barrier to quality care is social. The best care cannot save the patient who does not have access to care. Poverty, restrictive insurance, lack of sophistication of the patient, or merely shortages in resources may make access to needed care the major and rate-limiting barrier.

Sometimes the problem is defective or error-filled care. When this occurs, we often make the mistake of focusing on finding the single person or event responsible for the tragedy. We forget the fact that the vast majority of clinical errors are complex, involving multiple parties who participated in the care of the patient.

Clearly, it is becoming more difficult to practice error-free medicine. With the advent of managed care, the physicians and hospitals are being forced to do more with less, to be more productive with fewer resources, and to find cheaper ways of providing the care demanded. In all care settings, the resources are being stripped away: fewer nurses, less well-trained staff, fewer ancillary help, less optimal formulary medications. Every where we look, signs of frugality, even at the expense of safety.

Another barrier is the paper chart. At the time that the rest of the civilized world is abandoning the huge libraries of paper records that dominated law practices, accounting firms, and financial institutions, the medical profession is clinging to a major source of inefficiency and potential source of error – the infamous paper medical record.

But why, you may ask, my scurrilous attack on the hapless medical record, the venerable icon of modern medicine. Just watch a physician trying to answer his patient's questions about recent care, when the relevant documents are buried in the patient's two-inch paper record. Not only is the physical handling of the chart a tricky balancing act, made worse by the inevitable misfiled reports, but the chart can only be in one place at a time. If someone else needed access to the chart at the same moment, tough luck — you may wind up without the chart.

There are other issues as well. For instance, some of the most devastating errors occur because of medication errors. Incomplete lists of medications, errors in the dose of medication, the misreading of poorly written prescriptions, and lack of understanding about drug interactions are all examples of errors which have led to severe patient injury. These problems are easy to solve with an electronic medical record. In the more advanced systems, now available in internet versions, the physician can only choose actual doses of the particular medication, since the menu gives him a forced choice limited to the dosages available commercially. An automatic check of several hundred thousand possible drug interactions is instantly available, and then the final prescription is printed out on a laser quality printer.

At a time when the physician has fewer clinical personnel to help her, technology offers a lifeline that is hard to resist. Why not trade in our paper charts for a more organized and far faster system of handling our patient's data? For some, the major obstacle is the cost, which can be too high for the smallest practice. But this barrier will soon disappear, as the use of the less expensive web-based versions increase. For others, their main concern is that the confidentiality of the chart will be breached electronically. However, many financial corporations have done relatively well in this respect. Wells Fargo, for example, has very elaborate firewalls to protect the privacy of the financial records of their clients. A similar standard should and could be set for our patients.

Continued on page 21

Patient Safety

president's page

Continued from page 7

I think the most important barrier to using electronic medical records is inertia. Powerful and easy-to-use systems are now readily available for doctors. These systems result in marked increases in both physician and patient satisfaction. Also, they improve physician productivity. The patient often reports that the physician is spending more time with them. Physicians also report that they spend less time searching for information and need less time for dictation, leaving more time to be with their patient. An EMR will not make a poor physician a good one, but it will make a good physician better. In this era when the demand for error-free care is increasing, and the sophistication of the patient population is steadily increasing, our embrace of the newer and more powerful technology of the computer is not only good business sense, it is good medicine.

president's page

by **Richard Hellman,**
President, Metropolitan Medical Society

Science and Art

There are easier professions than medicine. Physicians are often alternatively vilified and adored, second-guessed by regulators, patients, scientists, and lawyers. It is no wonder that many of us often feel harassed and unappreciated. On the one hand, we are asked to be at the cutting edge of the newest scientific advances — the public demands no less. On the other hand, our patients and their families want us to be in touch with their human needs, the area of the art of medicine.

Most recently, it was the newer science that challenged me the most. Our office spent most of the past year in mortal fear of Y2K. Having made the fateful decision to join the computer revolution, we plunged into the Byzantine world of the electronic medical record, complete with examination room workstations, electronic prescription writing, and the complex interconnectiveness that evolves from the use of electronic notes that now pass instantly from provider to provider.

The experts told us that we needed to be Y2K compliant. And we worried. Would our technology all disappear in an electronic eye blink at midnight because of Y2K problems? Now that we were married to the maintenance of the interfaces, would we suddenly have a Nevada style divorce at the tolling of the clock bell at midnight, December 31, 1999? As this year's New Year's Eve celebrations began across the globe, as time zone after time zone was duly reported, I noted with relief that their fireworks exploded, their revelers reveled, their commentators commentated, and their lights stayed on. Then finally our turn came. Our lights stayed on, too. Despite the predictions of the wise pundits, it appeared that our computers merely shrugged, flipped to 1-1-2000 and continued to function, oblivious to the widespread human hysteria that surrounded them.

Hours later, near dawn, my wife and I found a hill south on Holmes Road where we had a good vantage point to see the first sunrise of the new century. Before dawn the sky became resplendent with fiery reds, the dark clouds hugging the horizon, outlined by the gaudy colors, which then gradually faded as the brilliant orb of the sun rose in the sky.

Later that morning, now off call, I visited a patient who was hospitalized in an area hospital. In the space of less than a month she had gone from being the matriarch of her family, busy caring for her ill husband, to fighting to maintain her emotional balance in the face of terminal cancer and a rapid inexorable decline. Throughout a busy workweek there is often so much competition for our time and so many distractions that it is very hard to provide all the time that our patients may need. This morning, on New Year's Day, there was no competition for my time, and I could listen without interruption to the patient, as she shared her thoughts, her fears, and her pain. She surprised me with her frankness and understanding of the needs of her family. She told me what would give her peace. At her request, I then called her husband and repeated her words to him. She wanted him to go back to work part-time after her death. She understood her husband well and knew his need to have some purpose to his day. Embarrassed, he choked back his tears. I reassured him that the prospect of the loss of his wife of nearly fifty years, his dearest friend, was more than an adequate justification for tears. It reminded me again that it has always been a privilege to practice medicine — to do what doctors do. And to do well at each of our diverse tasks. On the one hand, to try to adequately grasp and properly use the emerging sciences about us that change all-to-quickly and, on the other hand, to preserve the time to comfort our patients - the art of medicine - a task that sometimes I do well, but despite my efforts, not always.

This year will be challenging to us all, and particularly for the medical society. To keep our profession strong and to fulfill our public role, we need to focus on advancing scientific knowledge: to learn new techniques, new concepts, new solutions, and to reexamine what we are consistently doing, to make our work better and safer. At the same time, we need to preserve our skills in performing the art of medicine, to care for our patient's deeper needs.

We will find considerable support for our efforts. Unfortunately the opposition will be strong and varied, often out of ignorance but also because of different priorities, or self-interest. We will continue to focus on providing specific, and timely information to physicians in their continuing struggle with managed care companies over contract issues.

At the same time the public is asking us to include more people in the health care system and to improve the quality and safety of medical care. Perhaps this year will mark the end of the failed nationwide experiment to redesign health care by focusing almost entirely on cost cutting, but paying only lip service to quality of care issues.

Please contact me and let me know your point of view. Together we can better preserve both the science and the art of medicine and protect our patients.

President's Page by Richard Hellman, President, Metropolitan Medical Society, rhellman.hellman@hensmann.com

The Crushing Burden of Excessive Insurance Practice Expenses

The free-fall of American medicine is accelerating. Curiously, at the same time that national health care expenditures continues to rise, many physicians are in ever-increasing financial distress. At a time when employers and employees continue to face a larger financial burden for the increasing cost of care, physicians, particularly in Kansas City, are seeing their insurance payments shrinking, while their practice expenses are increasing beyond anything they had ever contemplated. Hospitals nationwide are facing a similar and often equally devastating experience.

Many months ago, I asked a deceptively simple question: What portion of our practice overhead is due to excessive insurance practice expenses? I already knew how much it cost to provide personnel to bill insurance companies and patients. I also knew how many people we needed to do pre-certification, verify insurance eligibility, check on benefits, and to argue with insurance clerks, nurses, and medical directors over medical necessity issues. I could calculate the cost of providing telephones, computer workstations, supplies, paper, and space for our personnel, but I had never considered how much of the costs was due to the added burden of the insurers putting unfair roadblocks in the way of reimbursement.

Let me explain. If all claims that were complete and "clean" were paid directly, the bill would need to be submitted only once, as we do for the vast majority of Medicare claims. Expenses such as these are clearly appropriate and are not excessive. But for many of the commercial insurance companies, four or five submissions of the same claim is necessary since payment is rarely given in response to the first claim, regardless of how well the claim was completed. When payment is finally received, a careful reading of the detailed explanation received from the companies often shows that an ever increasing number of payments are incorrect, almost always in the insurance company's favor, and very often inexplicable. We have to either pay for the time of our employees to challenge the company or accept incorrect and lower payments.

And then there are the interminable waits on the phone. Our nurses and clerks usually spend hours waiting on hold while attempting to comply with the insurance company rules regarding pre-certification of procedures -- even longer regarding disputes over the payment of claims. As the length of time waiting on hold has increased, so has our costs, and as the costs increased, our ability to sustain this effort decreased. A mid-size practice has limited resources. As the barriers increase in complexity and sophistication, either the practice costs increase, or the revenue from services already performed decreases. So what was the bottom line? For our practice, the excessive costs were 16 percent of our practice overhead

During the last several months, I have talked to many other physicians and practice managers, including **William F. Jessee**, CEO of the national Medical Group Management Association (MGMA). He has agreed to evaluate these excessive costs on a national basis. I have also spoken with hospital CEOs, both locally and in other cities, to encourage them to evaluate their excessive costs as well. One hospital executive will be asking the American Hospital Association to also investigate this issue. Key leaders both at the AMA and in my own

sub-specialty organization, the American Association of Clinical Endocrinologists (AACE), are also very supportive of our efforts.

Why is this issue is of both of national and local interest? It is because the dollars involved are huge. If our practice's excessive insurance costs are representative of most physicians, the total dollar figure from physicians alone could easily reach $50 billion annually. The excessive hospital costs might exceed that number. We are not even including the loss of productivity of physicians and nurses who are diverted from their direct responsibilities. Also, we have not discussed the wasted time and lost productivity of the patients when they become embroiled in a dispute over medical necessity issues. We probably have no way to calculate the increased medical costs when care delayed by insurance companies results in increased health burdens on the patient.

All of this money is clearly wasted money. These expenses serve no useful purpose from the patient's or providers' perspective. Much of the waste occurs because the physicians cannot expect to receive the money they have already earned in providing services to their patients. The patients were misled into believing that their insurance company would pay the physicians promptly and fairly, but the companies have often not done so. Sadly, if the public chooses not to help restore fairness, many health care providers may well be driven out of practice by the greed of some very large and powerful insurance companies.

We cannot expect many of the insurance companies to voluntarily change their behavior. They are just businesses trying to maximize their income. However, it is important to document the factual information in order to show the great strain their administrative rules have placed on physicians and hospitals and the adverse effects on the health care system as a whole. Ironically, the more burdensome the insurance-directed requirements, the more the financial advantage for the insurance company, and the worse the crisis in health care.

In the next two months, we will be collecting information from all physicians willing to help. Please do. The medical society will be providing forms to help you in this complex, but rewarding calculation. Most problems are solvable once the problem can be identified and clarified. Today, we are taking the first steps together. Perhaps tomorrow, these efforts will result in a fairer system of health care payment. I have no doubt, given the present disruption of quality care today, that a fairer payment system will result in a better health care system, with more resources for patient care without higher costs, because of the elimination of this crushing burden on us all.

A Little Music

By Richard Hellman
Chairman - National Health Reform Task Force
Metropolitan Medical Society

In the debate over health system reform, the experts have produced a deluge of numbers and statistics in order to prove change is needed and good. As a practicing physician, I recognize the value of the statistics, yet I also know there are important aspects of medicine which relate more to people and their human needs than to statistics and dollars.

Recently, I saw a patient, Mr. G., and his wife. His story reminds us how critically important it is to our patients that we attend to their deeply personal needs, even if it does not fit into the new definition of "cost-effective" medical care.

My staff and I always looked forward to seeing Mr. G. and his wife. For five years, I had been both his primary care physician and diabetes care specialist. Sadly, despite our best efforts over that time, his diabetes, hypertension, and multiple strokes had ravaged the very essence of this kind and gentle man, erasing much of his personality, robbing him of his memory, blinding him, and restricting him to a wheelchair.

His wife was always by his side, yet always alone. Throughout the many trials of caring for her husband, this deeply religious woman worked hard to keep him well and protect his dignity. As a result of her efforts, their casual acquaintances often would notice only the handsome, white-haired, well dressed man before them, and fail to notice the profound dementia that had already snatched him from his family.

A young medical student had elected to study with us that month. Earlier in the day, I had emphasized the importance of developing a strong bond with patients and their families, a bond built on mutual respect. In this regard, Mr. G. presented a problem, for he could barely remember from moment to moment.

He sat there, affable, but disconnected, disoriented with respect to time, place, and person. He no longer knew my name or why he was here. He could barely remember his wife's name and remembered few details of his past years. His wife was saddened; the medical student averted her gaze. Was there no way to comfort this man? Was there no way to communicate with him in a meaningful way?

Seeking a way to get in touch with him, I asked him what he enjoyed most about Sundays. It was his time spent in church. Mrs. G. added, with great pride, that her husband once had a fine baritone voice that was a joy to hear, especially when singing the hymns he loved so much. I asked Mr. G. if he remembered any of those hymns and asked him if he would sing to us.

Slowly, haltingly, he began to sing "Amazing Grace." His wife sang with him, as she had done for so many Sundays over the years, her rich alto vibrant, helping him with the words he could not recall. His voice quavered at first, then strengthened, his face lit up as their music filled the small exam room.

They finished the song together. For a moment, I think they forgot where they were. In a sense, they had briefly been transported back in time. Behind me, the medical student was crying softly.

Later, his wife thanked us. She felt that we were able to see a glimpse of the man she married and why she was so proud of him. I knew we had done more for him in this short visit than at any other time this past year.

I began wondering whether, in the new health care environment, I would be allowed to provide the care this family had just received. Even now, to tell a third party payer what really happened in that exam room was to guarantee non-payment - how do you find a payment code for singing hymns?

Under some current health proposals, Mr. G., being blind and demented, might be assigned a more "cost-effective" (cheaper) primary care provider, perhaps even a physician assistant or aide. If Mrs. G. wanted my services as an endocrinologist, she would need to present a specific request because of a particular problem. Even so, her request might be denied unless it met their "objective" criteria for specialty consultations.

In the search for objectivity, it is the non-quantifiable aspect of care, the art of medicine, that becomes the earliest casualty. Those of us who believe in the traditional role of the physician in providing both care and comfort, see a new threat. Profitability is becoming the most valued aspect of the health care delivery system. If the physician is not trusted or even allowed to provide a comforting word, a helping hand, or a wise observation, then we will not be allowed to provide the care that Mr. and Mrs. G. received that day.

I hope the Washington lawmakers remember not to tie the corset of efficiency too tight. There are times, even in health care, when all we need is a little music.

Cardiology - Private Practice →

21 years → Columbia →

(573) 256 3065

→ 85 Medicare HMO →

Been on medication 20 years

now prescription obtained by HMO Rx Drug Provider =

Sent prescription in for refill;

don't want to pay for it -

- Paid out-of-pocket
- gave samples
- He'll send a letter to try to get an altered opinion
- Pharmacy issue w/ HMOs

Had patients have had problems →

Patient - Post-heart attack -

came in Thurs

need bi-pass surgury → it's now Friday;

get a call from a Rhumatologist - from Cleveland -

\ medd directo/reviewer of HMO -

Can't stay in hospital over weekend →

won't discharge denies 2days →

Georgina Gonzalez - RN worked in a Physicians office since 1975

Make referral for patient to go to a specialists

sitting here waiting to hear from HMO

Rhumatologist - temporize w/ meds but

no one in the area (on the panel)

need to send 100-140 miles away from home - send to St. Louis or Kansas

[redacted] b/c Boy 8 years → if could have resulted in flare-up; increased need - continuity of care → 150 miles/way for Treat

Juvenile Rhumatoid Arthritis - for

→ gave a referral in Columbia - 3X went to Columbia ; then

HMO said must go to St. Louis

→ Then had to chose a new

only 1 person in the university

need to be seen every few weeks - chronic care

→ Was the family Physicians

→ Physician Nurse = need more staff

→ call woman @ HMO took several phone calls →

Cancer like diagnosis - got 2nd opinion

called 3X so can get 3 visits -

July 5, 2000

PATIENTS' BILL OF RIGHTS EVENT

DATE:	July 6, 2000
LOCATION:	Jesse Auditorium, University of Missouri Columbia, Missouri
EVENT TIME:	11:05am – 12:05pm
FROM:	Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

II. BACKGROUND

III. PARTICIPANTS

Stage Participants

YOU
Governor Mel Carnahan
Chancellor, University of Missouri
Real Person TBD

Program Participants

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

Richard Wallace - (573) 882-3387

- **YOU** will be announced onto the stage, accompanied by Governor Mel Carnahan, Chancellor ???, and Dr. ???.
- Chancellor ? will make welcoming remarks and introduce Governor Mel Carnahan.
- Governor Mel Carnahan will make brief remarks and introduce Dr. TBD.
- Dr. TBD will make brief remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline, and depart.

VI. REMARKS

To be provided by speechwriting.

VII. ATTACHMENT

- Patients' Bill of Rights Side-by-Side Chart.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003f. paper	Dr Gordon Goldman; RE: phone numbers [partial] (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Anna Richter
OA/Box Number: 23736

FOLDER TITLE:
Patients' Bill of Rights Columbia, Missouri July 6 2000

2011-0638-S
ms159

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

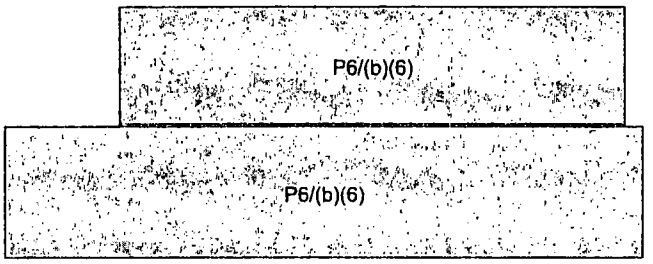
Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[003f]

DR Gordon Goldman President Missouri State American Association

(314) 878 7333



St. Louis –

referred by

Executive Director

Cork Sarenes – (573) 636 5151

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003g. email	From Devorah R Adler to Anna Richter; RE: phone number/personal info [partial] (1 page)	06/30/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Anna Richter
OA/Box Number: 23736

FOLDER TITLE:
Patients' Bill of Rights Columbia, Missouri July 6 2000

2011-0638-S
ms159

RESTRICTION CODES

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[0039]

Devorah R. Adler
06/30/2000 02:09:37 PM

Record Type: Record

To: Anna Richter/OPD/EOP@EOP

cc:
Subject: pbor - 2 stories

---------- Forwarded by Devorah R. Adler/OPD/EOP on 06/30/2000 02:09 PM ----------

Barbara D. Woolley
06/30/2000 02:08:44 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP, Karin Kullman/OPD/EOP@EOP

cc:
Subject: pbor - 2 sto

1. Kim Steil, P6/(b)(6) from Kansas City, MO. Kim's name was given to me by the AMA. About 2/3 weeks ago, the MO AMA used Kim in a press event. P6/(b)(6) P6/(b)(6) Articulate. YOU SHOULD ASK KIM IF SHE HAS SUGGESTIONS ON OTHER REAL STORIES.

2. Dr. Vicki Massey, Radiologist, 816-751-2930. Dr. Massey's name was given to use by the AMA. You should talk to her about her own personal experiences and ask for other names of real stories.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003h. paper	Dr Ted Groshong; RE: phone numbers [partial] (3 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Anna Richter
OA/Box Number: 23736

FOLDER TITLE:
Patients' Bill of Rights Columbia, Missouri July 6 2000

2011-0638-S
ms159

RESTRICTION CODES

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[003h]

Dr. Ted Groshong Pediatrician in Columbia

(573) 882-6882 P6/(b)(6)

Dr. Daley 4:00pm

(573) 815-2236

Dr. Mark Adams

(573) 443-2402

Nurse —

Sue Kendig P6/(b)(6)

Dr. Richard Helman → Kansas City, MO → 1993+1994 letter to the President

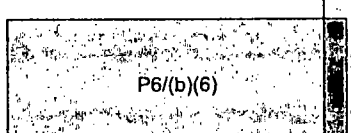
President of the Metropolitan Medical Society of Greater Kansas City

specializes in internal diabetes endocronology

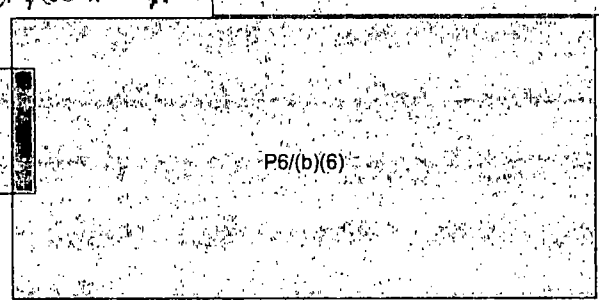
office: (816) 421 3700 - ~~Uttuber~~ - inside # of

(?) alternative #: P6/(b)(6)

don't leave message -



P6/(b)(6)



P6/(b)(6)

Dr. Murrell - Missouri Cancer Associates -

O: (573) 442-5525

IPmon @ 7(573) 815 3349

Radiation Oncologist -

Boone Hospital also =

Missouri State Medical Association

Chairman of Legislature Committee for

Rep
Tim Harlan } State Legislators
Sen Maxwell

metacisized
Testicular cancer, spread to
Lung Cancer

Response to Chemo = highly effective -

if all that's left is cancer or benine nodules -

if take out can get a cure sometimes -

didn't want to pay for surgery out of network + no surgeons in area could perform the surgery.

still treating him, but no longer in curreable stage

Missouri Nurses Association →

Sue Kendig → RN Nurse Practioner

Private Practice blends behavioral health w/ womens health care -

Managed care w/ pay for straight behavioral health or physical health →

as an independent Nurse Practioner -

internal medicine physician -

Pre-menopausal - 3 different D.s →

a doctor had assessed w/ temperature → thyroid getting tests & no communication →

Have a collaborated - written collaborated agreement -

Womens health + mental health → Blends the two

if in own practice → would be reimbursed -

what not paying for health prevention/promotion/ access →

Limits types of things

Specialists →

Heard Mrs. Gore → is Illinois

she is also → Vice-chair Greater Missouri March of Dimes -

[003h]

Neurosurgeon -

Hispanic -7

Record of going to the Philippines -

$50,000

total transfusions - crack skull

too many bones in head

new incision

technique - routinely denied by insurance companies

2 kids at hospital -

Mary -

office # 573 882 - 4908

P6/(b)(6)

Kathe O'Reico - specialty

David Jimenez

U of Mo -

P6/(b)(6)

Weldon Webb

[003h]

Jennifer Clark: (573) 443-2402 @church

— Columbia Orthopedic Group —

7-8
6-7

P6/(b)(6)

— Physical Medicine & Rehab ✱

✱ achilles tendon rupture — went to prescribe treatment 5

— 16 weeks — out should have

MISSOURI CANCER ASSOCIATES
RADIATION THERAPY
105 Keene Street, Suite 100
Columbia, MO 65201
573 442-5525
573 442-2124 FAX

DATE: 7-5-00

TIME: 11:05

TO: Karen Kullman

FROM: Dr. Murrell

TOTAL PAGES: 3

FAX NUMBER: 202-456-7028

Notice of Confidentially
Comments:

Mr. President:

Columbians are grateful for your visit to promote a meaningful Patient Bill of Rights. Our local legislators-Representative Tim Harlan and Senator Joe Maxwell – crafted a Statewide Patient Bill of Rights in 1997. With the help of our state medical associations and many individual physicians and patients, the bill passed and was signed into law by Governor Carnahan. That bill is among the toughest laws of any state in reining in the power of managed care companies. The Missouri Bill has served as a model for federal legislation. The Norwood-Dingle Bill which passed the U.S. House of Representatives is similar to the Missouri bill. That bill is now in a conference committee, which is attempting to blend the House version with a different Patient Bill of Rights which was passed by the U.S. Senate. That conference committee seems stalled; they have been meeting for months, but so far no compromise has been made public.

Managed care companies seem to attempt to practice medicine without being licensed to do so unless strict oversight is in place. A cancer patient of my practice group developed lung metastases from his testicular primary. The response to chemotherapy was dramatic – only a few lung nodules remained. There are data to suggest that surgical removal of such lung nodules – in SOME INSTANCES- MAY result in a cure. We were unable to convince the managed care company to pay for such an opportunity since the delicate surgery would have been done "out of network." The patient ultimately relapsed and now his cancer is beyond the

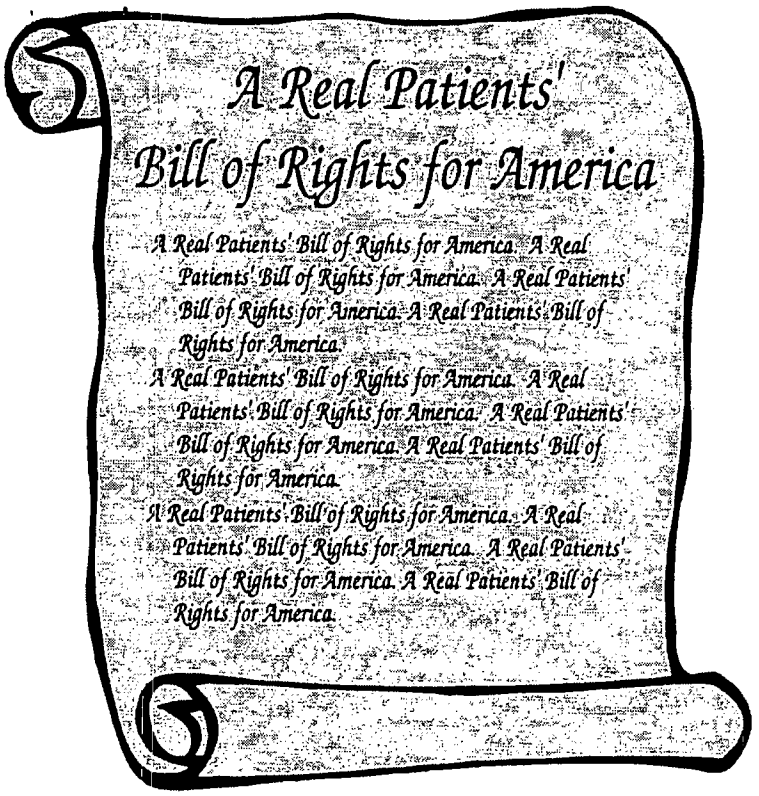
possibility of cure. Although, he is a Missourian, his managed care company could have been outside the scrutiny of even our state's fine law...if his company is protected by the ERISA federal legislation and cannot be made answerable to our state laws. The ERISA protection even precludes patients from seeking legal redress except under extreme circumstances.

Patients and physicians here in Missouri demand a meaningful Patient Bill of Rights – one that extends to as many citizens as possible – one that protects employers from harassment, but empowers patients to appropriate legal remedy after independent review. We have the best health care available in the world here in the United States. We beg for legislation which will bring that superb care to all our citizens in an accessible and affordable way.

Thank you for coming to Columbia to join us in asking Congress to work diligently to accomplish this goal.

Americans Deserve a Real Patients' Bill of Rights

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE *(Rejected by the House)*	BIPARTISAN NORWOOD-DINGELL PATIENTS' RIGHTS BILL *(Overwhelmingly Passed House - One Vote Short in Senate)*
Covers All Americans in All Health Plans	NO	YES
Ensures Access to Specialists	NO	YES
Barrier-Free Access to Emergency Room Care	NO	YES
Assures Access to Clinical Trials	NO	YES
Strong External Appeals Process	NO	YES
Plans Fully Accountable	NO	YES


A Real Patients'
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OLD version

Americans Deserve a Real Patients' Bill of Rights

Patient Protection	Senate Republican Leadership	President Clinton/ BiPartisan Proposals
Guaranteeing Access to Specialists	NO	YES
Providing Real Emergency Room Protections	NO	YES
Keeping Your Doctor Through Critical Treatments	NO	YES
Holding Health Plans Accountable for Harming Patients	NO	YES
Assuring HMO Accountants Don't Make Arbitrary Medical Decisions	NO	YES
Covering All Health Plans	NO	YES

COMPARISON OF THE FLAWED REPUBLICAN PATIENTS BILL OF RIGHTS AND THE STRONG BIPARTISAN NORWOOD-DINGELL BILL

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE	BIPARTISAN NORWOOD-DINGELL REAL PATIENTS' BILL OF RIGHTS
Covers All Americans	NO. Leaves out over 110 million Americans and covers less than 10 percent of all HMOs.	YES.
Ensures Access to Specialists	NO. ~~Does not provide meaningful continuity of care provisions~~	YES.
Barrier-Free Access to Emergency Room Care	NO.	YES.
Strong External Appeals Process	NO.	YES.
Holds Plans Fully Accountable	NO.	YES.
Provides Access to Clinical Trials	NO.	YES.

DRAFT

COMPARISON OF THE FLAWED REPUBLICAN PATIENTS BILL OF RIGHTS AND THE STRONG BIPARTISAN NORWOOD-DINGELL BILL

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE	BIPARTISAN NORWOOD-DINGELL REAL PATIENTS' BILL OF RIGHTS
Covers All Americans in All Health Plans	NO. Leaves out over 110 million Americans and covers less than 10 percent of all HMOs.	YES.
Ensures Access to Specialists	NO. Allows plans to limit access by hiring insufficient number of specialists and *imposing* significant geographical barriers.	YES.
Barrier-Free Access to Emergency Room Care	NO. Allows imposition of higher levels of co-payments if patient does not obtain prior authorization before going to the Emergency Room.	YES.
Assures Access to Clinical Trials	NO.	YES.
Strong External Appeals Process	NO. Allows health plan to select external appeals reviewer.	YES.
Holds Plans Fully Accountable	NO.	YES.

DRAFT

COMPARISON OF THE FLAWED SENATE REPUBLICAN BILL AND THE BIPARTISAN NORWOOD-DINGELL PATIENTS' BILL OF RIGHTS

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE (Rejected by House)	BIPARTISAN NORWOOD-DINGELL PATIENTS' RIGHTS BILL (Overwhelmingly Passed House – One Vote Short in Senate)
Covers All Americans in All Health Plans	NO	YES
Ensures Access to Specialists	NO	YES
Barrier-Free Access to Emergency Room Care	NO	YES
Assures Access to Clinical Trials	NO	YES
Strong External Appeals Process	NO	YES
Holds Plans Fully Accountable	NO	YES

DRAFT

COMPARISON OF THE FLAWED SENATE REPUBLICAN BILL AND THE BIPARTISAN NORWOOD-DINGELL PATIENTS' BILL OF RIGHTS

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE (Rejected by House)	BIPARTISAN NORWOOD-DINGELL REAL PATIENTS' BILL OF RIGHTS (One Vote Short in Senate)
Covers All Americans in All Health Plans	NO	YES
Ensures Access to Specialists	NO	YES
Barrier-Free Access to Emergency Room Care	NO	YES
Assures Access to Clinical Trials	NO	YES
Strong External Appeals Process	NO	YES
Holds Plans Fully Accountable	NO	YES

Devorah R. Adler
05/30/2000 05:59:28 PM

Record Type: Record

To: Anna Richter/OPD/EOP@EOP, Barbara D. Woolley/WHO/EOP@EOP, Karin Kullman/OPD/EOP@EOP

cc:

Subject: descriptions of PBOR people

Here are some specific descriptions of PBOR people, as per your request. Can you mobilize the groups?

Thanks, Devorah

PROVIDER

This person can be either a physician or a nurse. They should not be a member of the group's leadership. They should be currently practicing and have a large volume of managed care patients. They should be able to tell stories of patients that have the following salient points:

- Patient was denied care by managed care company
- Provider appealed HMO decision and was denied
- Patient suffered adverse effect as a result

OR

- Patient was denied care by managed care company
- Provider appealed HMO decision
- Appeal took so long that even though patient eventually got their care, they were harmed by the delay

They should be able to provide specific details about the stories (with respect for confidentiality), and should have more than one if at all possible. *The health care provider appealing the decision is a critical part of this story.*

REAL PERSON

This person can be a man or a woman. Their story should include the following salient points:

- Patient was denied care by managed care company
- Provider appealed HMO decision and was denied
- Patient suffered adverse effect as a result

OR

- Patient was denied care by managed care company
- Provider appealed HMO decision
- Appeal took so long that even though patient eventually got their care, they were harmed by the delay

OR

- Patient called advice nurse

- Advice nurse either denied appointment or delayed appointment
- Delay or denial of care caused harm to patient

They cannot currently be attempting to sue their managed care company or their provider. If they have settled their claim or have yet to bring a claim, that's fine. Also, we are not looking for stories where the doctor did not do the right thing because of financial incentives provided by managed care companies. We are also not looking for stories where the physician misdiagnosed the treatment because of their limited time with each patient.

LEVEL 1 - 1 OF 3 STORIES

THE KANSAS CITY STAR

June 22, 2000, Thursday METROPOLITAN EDITION

SECTION: BUSINESS; Pg. C1

LENGTH: 845 words

HEADLINE: Patients' bill gets a boost;
Ashcroft says he would support a plan that protects employers from lawsuits

BYLINE: PAUL WENSKE; The Kansas City Star

BODY:

U.S. Sen. John Ashcroft on Wednesday said he would support a patients' bill of rights that holds insurers accountable for misconduct but limits liability for the nation's employers.

Ashcroft's statement underscores the increasing importance of health care in Missouri's U.S. Senate race and in the presidential election. Physicians groups also have become more politicized.

Ashcroft issued his statement the same day that representatives of the American Medical Association came to Kansas City to spark public support for a patients' bill that reduces the role of insurance companies in making medical care decisions.

The medical association's "house call" campaign focuses on three states - Missouri, Michigan and Washington - to pressure Republican senators to approve a patients' rights bill that would allow patients to sue their HMOs.

The campaign began a week after a strong patients' rights bill that would have provided protection for thousands of patients failed to pass in the U.S. Senate by a 51-48 vote.

Ashcroft voted against the bill, which did not protect employers who provide health-care benefits to their employees from being sued. Last year he voted for a Republican-backed bill that also did not include any provisions to let patients sue their HMOs.

But Ashcroft's statement Wednesday appeared to show his willingness to support a bill that would penalize HMOs for wrongdoing but would still limit a patient's right to sue.

The statement said Ashcroft would support a law "that puts doctors and patients in charge of their health care, gets patients care when they need it and protects Americans' access to affordable high-quality care."

He said, however, that he was "concerned that employers who

simply choose to provide the benefit of health coverage to employees be protected when they have done no wrong."

Ashcroft has pushed his own provision in the Senate that would make HMOs abide by strict timetables and face penalties for non-compliance with medical findings of external physician reviewers.

Last week Ashcroft's U.S. Senate opponent, Gov. Mel Carnahan, released to the press a letter he sent to Ashcroft urging him to vote for a broader patients' rights bill. Carnahan has gained ground with Missouri physicians, who normally vote Republican.

"A lot of doctors who are supporting the governor are doing so because he supports the patients' bill of rights," said Sara Howard, Carnahan's deputy communications director.

Wednesday, Thomas R. Reardon, former president of the medical association, met with local physicians, patients and news media. He made it clear the association was pressuring Ashcroft for support.

"If your senator in Missouri votes for this bill of rights, it will pass," Reardon said, referring to Ashcroft. "We need to make the Congress understand patients need this bill.

"Polls all across the country show people want this bill, but insurance companies and the U.S. Chamber of Commerce are fighting it tooth and nail."

During his visit Reardon spoke with Kim Steil of Olathe, whose husband has a brain tumor. Steil said her husband's HMO has refused to pay for treatments it considers experimental, even though the exact same treatment is covered by other insurers.

"What we need is more consistency so that all patients are protected," Reardon said in response. "This is not a partisan issue. This is a patient issue."

Bill Dorzab, former president of the Missouri Medical Association, said that in recent conversations, Ashcroft has shown greater support for the physicians' position. He said that physicians were willing to limit lawsuits in the bill.

Physicians support a patients' bill with four principles:

All medical care decisions are made by physicians, not insurers.

Patients are provided an appeal process if care is not covered.

Insurers can be sued for misconduct that causes harm.

All patients would be covered by the federal rights bill.

Carl Strauss, a Kansas City internist, was one of several physicians who met with Ashcroft in February in Washington. He said

Ashcroft appears willing to compromise.

"It sounds like we're very close," Strauss said. "We'd be very proud to have Missouri put this over the top."

Strauss said physicians aren't about to let up the pressure, now that they have realized their new political clout. "We're now seeing how we can use the system more effectively," he said.

"Over the years physicians have found themselves inclined toward the Republican philosophy, but in the last few years the party's tilting toward business interests rather than patient interests have sort of turned physicians off.

"They (physicians) feel that a number of patient interests have not been supported properly and that Democrats have taken up the flag on this."

- To reach Paul Wenske, consumer affairs reporter, call (816) 234-4454 or send e-mail to pwenske£kcstar.com
£ART CAPTION:Ashcroft
£ART:Photo (color)

LOAD-DATE: June 22, 2000

LEVEL 1 - 2 OF 3 STORIES

Knight Ridder/Tribune News Service
The Kansas City Star

December 13, 1999, Monday

SECTION: DOMESTIC NEWS

KR-ACC-NO: K7366

LENGTH: 1453 words

HEADLINE: 'Medical necessity' issue puts patients, health-care providers at odds

BYLINE: By JULIUS A. KARASH

BODY:

KANSAS CITY, Mo. _ Keith Steil already was battling brain cancer when he got into a new fight.

Steil, a 38-year-old Olathe, Kan., resident and father of two, this month sued Humana Health Care Plans Inc. The lawsuit, which was filed in federal court in Kansas City, Kan., contends that Humana refused to pay for a brain cancer treatment that Steil's doctor recommended.

In letters sent to Steil, Humana officials have said Humana will not cover the treatment, known as "blood brain barrier disruption," because it is considered experimental.

Steil is receiving the treatments, which consist of injections that are meant to make brain tumors more treatable by chemotherapy. Each treatment costs thousands of dollars. Steil and his wife, Kim, have been agonizing over Humana's decision not to pay.

"I should be taking care of my husband and my children," Kim Steil said. "Instead, I'm spending a lot of time and energy fighting for approval from the insurance company. Half the time I forget the calls I need to make or the things I need to do."

Zarina Shockley-Sparling, executive director of Humana health plans in the Kansas City area, said Humana did not comment on individual cases, because of confidentiality concerns.

She said, however, that Humana "puts the health and wellness of our members as our No. 1 priority."

Steil is one of many consumers around the country who have gotten into disputes with their health insurance companies in recent years. Many of the disputes relate to the issue of medical necessity, or who should decide what is medically necessary for a patient.

Medical necessity is one of the issues that surfaced recently in a contract

dispute between at least 1,000 area doctors and Blue Cross and Blue Shield of Kansas City.

Blue Cross said last week that it was willing to talk to doctors about the issue, which has been influenced by a national backlash against managed care. UnitedHealthcare, for instance, recently said it would no longer require doctors to seek approval before recommending medical treatment or hospitalization.

While the controversy may seem like a power struggle between doctors and insurance companies, the ultimate outcome affects health-care consumers.

"The consumer is the end user of the plan and gets caught in the middle of the fight between what the physician is recommending and what the insurance company will approve," said Karen Daugherty, head of the Kansas City office of Aon Consulting, a benefits consulting firm.

Take Linda Belinke, a 52-year-old Prairie Village, Kan., resident who is undergoing reconstructive breast surgery after having a double mastectomy to treat breast cancer. She said a Blue Cross official told her employer in mid-November that the Blue Cross doctor contracts were "in place" and that "everything is fine."

She subsequently learned that her plastic surgeon had not signed the Blue Cross contract, and she feared she could not keep using him.

"I was horrified and devastated," she said. "I couldn't believe it."

To make sure she could continue to see her surgeon, Belinke dropped out of the Blue Cross HMO and switched to another plan.

Belinke has since learned that her plastic surgeon planned to sign an amended contract with Blue Cross and that Blue Cross would have continued to cover her treatment by the surgeon, whether he signed with Blue Cross or not.

Belinke's employer is trying to help her get back into the Blue Cross HMO, but the experience has left her leery of the health-care system.

"I still have a concern that in the future ... these types of situations can continue to occur," she said. "HMOs have just pushed it too far. I get worried that they're so focused on the bottom line that they forget they're in the business of providing health care."

Catherine Edwards, executive director of the Missouri Association of Health Plans in Jefferson City, said managed care companies generally approved coverage of most medical procedures recommended by a patient's physician. When such coverage undergoes greater scrutiny, managed-care companies look at cost and quality.

"Managed-care companies try to compare physician practices in their networks to national guidelines established by their peers in their own medical specialty groups," Edwards said. "That concern for quality helps patients."

Donald B. White, a spokesman for the American Association of Health Plans in Washington, said insurance companies generally approved nearly all medical

services recommended by physicians.

White said an independent study based on 1995 data, the latest available, showed that insurance companies approved at least 94 percent of such recommendations. Ultimately the insurance companies agreed to pay for between 97
percent and 99.3 percent of such services, the study showed.

Patti Beardall, a 47-year-old Shawnee, Kan., resident who has hepatitis C, said, however, that she had to fight with Blue Cross and Humana to get them to pay part of the cost for vaccines for hepatitis B and hepatitis A.

"How I really feel is scared," Beardall said. "It's my health, and I don't know if I can trust the system now."

The medical necessity debate is about consumers, said Richard Hellman, president-elect of the Metropolitan Medical Society of Greater Kansas City.

"They have to realize that their safety is endangered if a company can profit by denying them care," he said. "Although not every company would do that, the temptation is great, and some do."

Some doctors have decided not to deal with health insurance companies at all. One of them is Jane L. Murray, a physician who operates the Sastun Center of Integrative Health Care in Mission, Kan.

The center incorporates alternative therapies such as acupuncture into traditional medical procedures.

Patients at the center may seek reimbursement from insurance companies, but Murray and her colleagues do not seek or accept payments from insurance companies.

Not every health-care dispute involves doctors as consumer champions. Beardall, for instance, said she got into a dispute with a doctor over whether she should have received additional tests for a possible liver problem. Beardall wanted to have the tests, but her doctor said they were unnecessary.

Beardall said the doctor finally called her a "nervous ninny" and abruptly dismissed her from his office.

Beardall, who also suffers asthma and a digestive problem, said she had concluded that the health-care system as a whole "doesn't work a lot of the time if you have chronic illnesses."

Industry officials say they are trying to make it work.

John P. Mascotte, president and chief executive officer of Blue Cross, said the health insurer could not discuss individual members' cases.

"But our philosophy has always been to put the health of our members first and foremost," Mascotte said. "It's our constant focus, underpinning everything we do, from the design of our health plans to our medical review procedures to the training of our customer service team."

Missouri has an external review procedure for medical necessity disputes between consumers and insurance companies, and Kansas is instituting a similar procedure Jan. 1.

In Kansas an independent physician will review medical necessity disputes after an insurance company's internal appeals process has been exhausted. The independent physician will then make a recommendation to the insurance commissioner, who will implement that decision.

"We think this is going to change the landscape of the consumer complaint process," said Denney Clements, director of public information for the Kansas Insurance Department.

The Missouri system works similarly but does not require the consumer to complete all internal appeals with the insurance company before turning to the state.

The Missouri external review system and the planned Kansas system do not apply to consumers who receive health insurance from so-called self-funded insurance plans, which come under the supervision of the U.S. Department of Labor. Efforts are under way in Washington to extend external review protections to members of self-funded plans.

Under a self-funded plan, an employer assumes the financial risk for employees' health-care costs and typically pays an insurance company to administer the plan. Consumers should ask their personnel departments what type of plan they are in.

Meanwhile, consumers hope that doctors and insurers will live up to their stated goals.

"Health insurers need to realize that they and the doctors are there to provide service to consumers," Belinke said. "They need to work as a team."

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